The Status of

EPSD&T

Early Periodic Screening Diagnosis & Treatment

What is EPSDT?

EPSDT means Early and Periodic Screening, Diagnosis and Treatment, a program of comprehensive health care intended for needy children who are eligible for medical assistance under Medicaid.

EPSDT and MEDICAID

Medicaid, the parent program of EPSDT, is a Federal-State program, enacted in 1965, to pay the basic medical costs of certain low-income persons. Under Medicaid, the Federal government provides funds to States to help them defray the medical expenses of needy individuals who cannot afford their own care. The Federal government establishes broad policy guidelines concerning who is eligible for the program, what services they must be provided, and basic administrative practices. But within these limits, the States design and administer their own Medicaid programs. They also decide whether to have a Medicaid program at all. All States and territories except Arizona currently do. Arizona expects to begin a Medicaid program in 1976.

Eligibility for Medicaid is closely tied to eligibility for public assistance. According to Federal law, individuals are, with minor exceptions, eligible for Medicaid if they are receiving Supplemental Security Income payments available to low-income persons who are *aged, blind,* or permanently and totally *disabled,* or if they *are members of families with dependent children* (AFDC) eligible for Federal-State welfare payments. State Medicaid programs have the option of covering, in addition, persons who fit in the SSI and AFDC categories but whose income and resources are somewhat above the level required for money payments. Among the additional groups that may be covered are all needy children under 21, regardless of their family status.

The services provided under Medicaid are designed to meet recipients' most critical health needs. In every State, Medicaid must provide eight essential health services, including such costly services that recipients are least able to afford themselves as inpatient hospital care, nursing-home care, and physicians' services. EPSDT is also a required service. In addition, States may choose to pay for a number of optional services, prescription drugs and dental care, for example.

The financing of Medicaid draws on both Federal and State funds and the State share may include local funds. The Federal government pays its share by matching certain percentages of State expenditures. The Federal share of Medicaid expenditures averages 55 percent nationally, the rate varying from State to State between 50 percent and 78 percent in inverse ratio to the State's per capita income.

Medicaid has been expensive. It is the costliest and fastest growing of all Federal-State public assistance programs. The Federal share of Medicaid was $6.8 billion and the State share $5.6 billion in fiscal year 1975, and each figure has risen by about $1 billion a year. EPSDT will soon account for an important part of these expenses. On the other hand, one of the arguments for EPSDT is that it will eventually reduce Medicaid and welfare costs by reducing illness and dependency among the poor.

Eligibility for EPSDT is closely tied to eligibility for Medicaid, just as Medicaid eligibility is closely tied to public assistance. In every State, all children under 21 who are eligible for Medicaid are also eligible for EPSDT. A child need not be on public assistance or eligible for it; he need only qualify for Medicaid. The groups of needy children that are eligible for Medicaid, and therefore for EPSDT, vary with each State. In States where all needy children under 21 are eligible for Medicaid, all needy children are also eligible for EPSDT. About 13 million children are eligible for EPSDT nationwide.

EPSDT services are a required part of every State Medicaid program. Every child under 21 eligible for Medicaid must be offered EPSDT. EPSDT includes not only screening for certain important health disorders, but referral for diagnosis and treatment where necessary. The entire process should be repeated periodically for each child. EPSDT also differs from the rest of Medicaid in that the State program must actively seek out eligible children and notify them that preventive health services are available and arrange for screening, diagnosis and treatment services on request.

The Reasons for EPSDT

EPSDT's goal is to provide comprehensive health care to low-income children with severe unmet health needs. The public also has an interest in improving the health care of the needy because this not only benefits the children but should eventually reduce dependency among the poor.

Low-income children are badly in need of care. This is clear from the children who have already been served by EPSDT. Nearly half the children screened under the program have had to be referred for diagnosis and treatment. The incidence of dental problems is especially high; incomplete immunizations and vision and hearing defects are high also. Furthermore, the conditions uncovered by screening are frequently serious. In one sample study, 90 percent of the problems found were either unknown or previously untreated. Of these 11 percent were serious or advanced problems and 25 percent moderately serious. It is clear that low-income children are many times more prone to a number of serious health disorders than children who are better off.

At the same time, low-income children lack adequate access to health care. A study of low-income children done in 1967 found that 20 percent to 40 percent suffered from one or more chronic conditions, but only 40 percent of the conditions were under treatment. Sixty percent of low-income children at any given time have never seen a dentist. Less than two-thirds have been fully immunized against infectious diseases, and less than half against polio. The immediate reason for EPSDT is simply to provide access to quality health care for children who need it and have not had it in the past.

But another reason for EPSDT is that it can actually save the public money. Needy children are part of a low-income population that suffers disproportionately from unemployment and other conditions leading to dependence on public support. Some of this dependency is due to handicapping health conditions. If the health of low-income people can be improved, there is a better chance that the "welfare cycle" can be broken. The cost of EPSDT may be more than recompensed by savings in welfare, Medicaid, and other forms of public assistance.

We already have evidence that preventive care is a good investment. Our existing preventive programs for needy children, including some EPSDT projects and the Title V Maternal and Child Health Programs have brought about encouraging savings in regular health care expenses. One reason is that the health disorders of children are often correctable, and early prevention or correction usually costs less than treatment later in life. One study of low-income 18-year-olds rejected by the Selective Service found that 33 percent of their health conditions could have been prevented or corrected if treated before age nine, and 62 percent could have been prevented or corrected before age 15. Another reason preventive programs bring savings is that they often provide health-education and case management services which help patients use health services more efficiently than they could on their own. A study done in Portsmouth, Virginia, showed that the assistance of a trained health aide reduced the use of physicians services, hospital care, and prescribed drugs by 33 to 50 percent.

Therefore, the public-policy case for EPSDT is strong. Low-income children are badly in need of health care, and there is reason to believe that providing them with preventive care through EPSDT can yield important savings to the public in terms of other health costs and public assistance.

Putting EPSDT to Work

Early progress in implementing EPSDT has been slow. The program was enacted by Congress in 1967 and became effective in 1969. HEW's regulations and guidelines for the program were published and became effective in 1972. Although it was never intended that all 13 million eligible children be screened every year, the program has not yet achieved its full potential of screening and providing necessary treatment for the 3½ to 4½ million children a year that it should when the program is operating maximally. As of July 1975 about three million of the 13 million children eligible for the program had been screened and referred for necessary treatment. One and a half million of these were screened in FY '75 alone.

Various reasons account for the difficulties. The EPSDT program is complex and presents unprecedented challenges to State Medicaid programs. State Medicaid agencies have usually taken the reimbursement of health providers for individual services rendered to Medicaid recipients as their sole function. EPSDT requires States, in addition, to seek out children eligible for EPSDT, notify them of the services available, and arrange for screening, if requested, and diagnosis and treatment if needed. States often lack administrative resources to do this, particularly at the local level. They usually must make cooperative arrangements with local school and health facilities in order to deliver EPSDT services. Other problems include lack of funds (even though the Federal government pays most of the cost of EPSDT, as it does for Medicaid) and insufficient numbers of medical care providers to serve EPSDT children.

In 1972, Congress acted to hasten implementation of EPSDT by imposing a financial penalty. The penalty law provides that States that are delinquent in implementing EPSDT will lose one percent of their Federal matching funds for AFDC, the major public assistance program. Regulations for the penalty, which became effective in July 1974, detailed what State programs must do to inform eligible people about EPSDT, provide screening for them, and arrange for diagnosis and treatment if necessary.

The Federal government is helping States to implement EPSDT. The Social and Rehabilitation Service's Medical Services Administration which administers the Medicaid program at the Federal level has begun an extensive program of technical assistance to help States overcome problems with EPSDT. One approach is to inform all States about the procedures used by the States that have implemented the program more successfully. Another is to enlist the help of medical and dental professional organizations in writing guidebooks for various aspects of the program and to work with these organizations to enlist the support of the professional community.

Implementation of the program has recently accelerated as a result of these initiatives. Increasing numbers of needy children are being screened by State EPSDT programs. Soon, States will be able to shift their emphasis from the initial screening to follow-up diagnosis and treatment services—and then to the periodic repetition of the process for each child.

The Larger Implications

EPSDT has broad implications for American public health care programs. In a number of ways the program breaks new ground for Federal health care policy:

EPSDT is the first Federal health care program to have the potential to serve nearly all needy children. Previous maternal and child health programs reached only relatively small numbers of recipients. EPSDT covers most needy children in every State and States have the option of covering all needy children.

EPSDT is the largest Federal program to provide comprehensive care to this group. Previous programs have either not offered comprehensive services, or have served only limited numbers. EPSDT provides dental, vision, and hearing care even if these services are not available to other Medicaid beneficiaries in the State.

EPSDT is an outreach program. Whereas other health care programs, including Medicaid itself, have provided services only when requested by recipients, EPSDT requires the States actively to seek out all those eligible for the program and offer them services. The States bear substantially more responsibility than they did previously to see that needy children actually receive the services available.

Because of these features, EPSDT provides many lessons for future health care programs in the United States.

EPSDT

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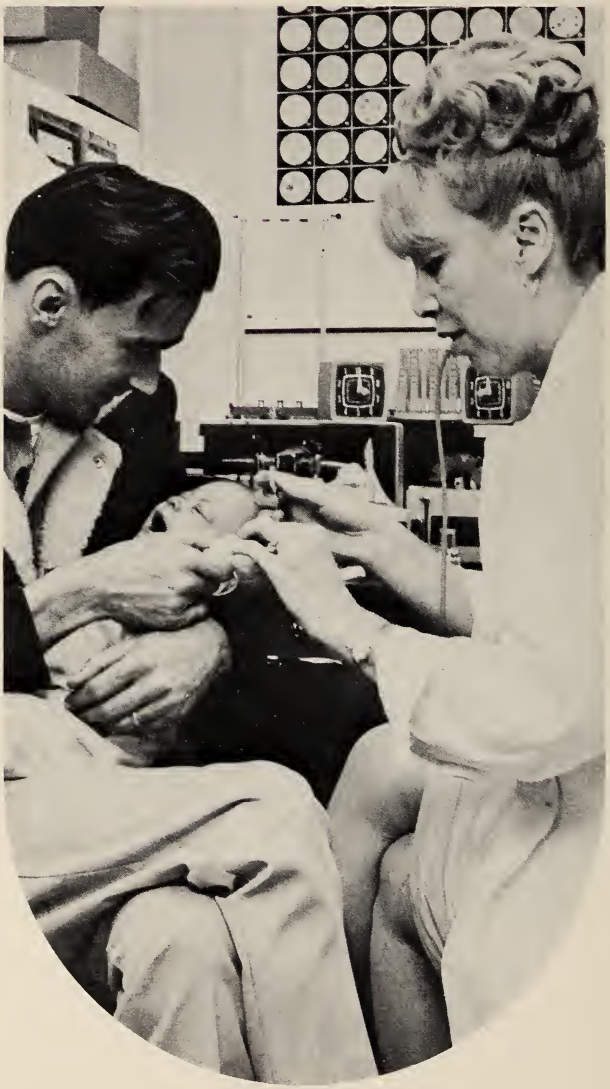

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